Professional Pediatrics
Consent Treat

I hereby give permission for the following people to obtain medical care
Of my child (_____, DOB _____):

_____	_____
Name	Relationship/Phone Number
_____	_____
Name	Relationship/Phone Number
_____	_____
Name	Relationship/Phone Number

_____ I do not wish to give permission for additional family members, relatives or or close personal friends to obtain medical care for my child in my absence nor to have access to any information regarding my child's medical condition(s).

_____	_____
Signature of Parent or Guardian	Date